

**Health Net of California, Inc.  
HMO 40 HIPAA Plan**

This benefit summary is intended to help you compare coverage and benefits and is a summary only. For a more detailed description of coverage, benefits, and limitations, including any related exclusions not contained in this benefit summary, please contact the health care service plan or health insurer. The comparative benefit summary is updated annually, or more often if necessary to be accurate. The most current version of this comparative benefits summary is also available on [www.healthnet.com](http://www.healthnet.com) or the DMHC's website [www.dmhc.ca.gov](http://www.dmhc.ca.gov).

<b>Plan Name</b>	<b>Plan Contact Name and Phone Number</b>
Health Net HMO 40 HIPAA Plan Offered by Health Net of California, Inc.	Health Net Individual and Family Sales (800) 909-3447

**Coverage summary**

Eligibility requirements	<p>Applicants who meet the following requirements are eligible to enroll in Health Net's Guaranteed Issue HMOs and PPOs, without underwriting. Specific Guaranteed Issue rates apply. Only eligible individuals qualify for guaranteed issuance. To be considered an eligible individual:</p> <ul style="list-style-type: none"> <li>--The applicant must be under the age of 65</li> <li>--The applicant must not be eligible for Medicare</li> <li>--The applicant must reside continuously in our service area</li> <li>--The applicant must have a total of 18 months of coverage (including COBRA, if applicable) without a significant break (excluding any employer-imposed waiting periods) in coverage of more than 63 days.</li> <li>--The most recent coverage must have been under a group health plan (COBRA and Cal-COBRA coverage are considered group coverage).</li> <li>--The applicant must not be eligible for coverage under any group health plan, Medicare or Medicaid, and must not have other health insurance coverage.</li> <li>--The individual's most recent coverage could not have been terminated due to fraud or nonpayment of premiums.</li> <li>--If COBRA or Cal-COBRA coverage was available, it must have been elected and such coverage must have been exhausted.</li> </ul>
The full premium cost of each benefit package in the service area in which the individual and eligible dependents work or reside	See Health Net HMO 40 HIPAA Plan rates

When and under what circumstances benefits cease	<p>You may cancel your coverage at any time by giving Health Net written notice. In such event, termination will be effective on the first day of the month following our receipt of your written notice to cancel. Health Net has the right to terminate your coverage for any of the following reasons:</p> <ul style="list-style-type: none"> <li>--You do not pay your premium on time</li> <li>--You and/or your family member(s) cease being eligible</li> <li>-- You omit or misrepresent a material fact in the application</li> <li>-- You fraudulently or deceptively use services or facilities of the Plan, its contracting Physician Group or other contracting providers, (or knowingly allow another person to do so), including altering a prescription</li> <li>--You and/or your family member(s) repeatedly or materially disrupt the operations of the Physician Group or Health Net to the extent that your behavior substantially impairs Health Net's ability to furnish or arrange services for you or other Health Net members, or the physician's office or Contracting Physician Group's ability to provide services to other patients.</li> <li>--You and/or your family member(s) threaten the safety of the health care provider, his or her office staff, the contracting Physician Group or Health Net personnel if such behavior does not arise from a diagnosed illness or condition</li> </ul>
The terms under which coverage may be renewed	Subject to the termination provisions discussed, coverage will remain in effect for each month prepayment fees are received and accepted by Health Net. You will be notified 30 days in advance of any changes in fees, benefits or contract provisions.
Other coverage that may be available if benefits under the described benefit package cease	N/A
The circumstances under which choice in the selection of physicians and providers is permitted	When you enroll in this Plan, you must select a Physician Group where you want to receive all of your medical care. That Physician Group will provide or authorize all medical care. See the Health Net Individual HMO Physician Directory or call the Member Services Department at the number on your Health Net ID Card for a listing of participating providers in the Health Net Individual HMO Service Area.
<b>Annual Out-of-Pocket Maximum</b>	\$3,000 Individual/\$6,000 Family (Calendar Year Deductibles and certain copayments apply to Annual Out-of-Pocket Maximum)
Lifetime and annual maximums	No lifetime maximums
Deductibles	\$1,500 per member calendar year deductible for inpatient hospital facility services (prescription deductible applies)

<b>Benefits Summary (*1) &amp; (**2)</b>		<b>Co-payments</b>	<b>Limitation</b>
Professional Services	Physician office visits, including, but not limited to preventive care, immunizations, screenings and diagnostic visits.		
	Visit to physician	\$40	
	Specialist consultations	\$40	
	Prenatal and postnatal office visits	\$40	
	Periodic health evaluations	\$40	
	Vision screenings and exams	\$40	
	Hearing screenings and exams	\$40	
	Immunizations - Standard	\$40	
	Immunizations – To meet foreign travel or occupational requirements	20%	
	Prostate cancer screening and exam	\$40	
	Annual OB/GYN exam (breast and pelvic exams, cervical cancer screening and mammography)	\$40	
	Allergy testing	\$40	
	Allergy injection services	\$40	
	All other injections	covered in full	
	Allergy serum	covered in full	
Outpatient Services	Outpatient services, including, but not limited to surgery and treatment, and diagnostic procedures.		
	Outpatient services other than surgery	covered in full	
	Outpatient surgery	\$250	
	X-ray and laboratory procedures	covered in full	
	Rehabilitative therapy (includes physical, speech, occupational and respiratory therapy)	\$40	
	Vasectomy	\$150	
	Tubal ligation	\$150	
Hospitalization Services	Inpatient and outpatient services, including, but not limited to room board		

	and supplies.		
	Hospitalization - Semiprivate hospital room or intensive care unit with ancillary services (unlimited, except for non-severe mental health and chemical dependency treatment)	\$1,500 deductible applies per calendar year for inpatient services	
	Maternity care in hospital or skilled nursing facility	covered in full after \$1,500 inpatient hospital services deductible has been met	
	Surgeon or assistant surgeon services	covered in full	
	Physician visit to hospital (excluding care for substance abuse and mental disorders)	covered in full	
Emergency Health Coverage	Emergency room services at contracted and non-contracted facilities for medically necessary emergency services.	\$100 (waived if admitted to hospital)	
Ambulance Services	Emergency ambulance transport.	\$80	
Prescription Drug Benefits	Medically necessary drugs prescribed by a physician.		The Health Net Recommended Drug List is the approved list of medications covered for illnesses and conditions. Some drugs on the List may require prior authorization from Health Net. Drugs that are not listed on the List that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net.
	Prescription drugs filled at a participating pharmacy (up to a 30-day supply)	\$100 calendar year deductible*** <sup>3</sup> per member, then \$15 Level I (primarily	

		generic); \$25 Level II (primarily brand name, including peak flow meters and inhaler spacers); \$50 Level III Drugs on the Recommended Drug List (or drugs not on the Recommended Drug List)	
	Diabetic supplies (including but not limited to pen delivery systems and blood glucose monitoring strips, insulin needles and syringes. Lancets will be dispensed at no charge. Diabetic supplies are not subject to the prescription drug deductible.	\$25	
	Diabetic prescription medications (including but not limited to insulin and glucagon)	\$25	
Durable Medical Equipment	Home medical equipment, including, but not limited to, oxygen, parenteral and enteral nutrition, colostomy supplies, corrective prosthetics and aids, nebulizers, face masks and tubing for the treatment of asthma and diabetic supplies.		
	Durable Medical Equipment	50%	
	Prostheses	covered in full	
	Diabetic equipment (includes blood glucose monitors, insulin pumps and corrective footwear)	\$25	
Mental Health Services	Inpatient, partial hospitalization and outpatient mental health services, including, but not limited to, mental health parity services for serious mental disorders and severe emotional disturbances for children.		
	Mental health services for severe mental illness and serious emotional disturbances of child conditions	Outpatient: \$40 Inpatient: \$1,500 deductible applies per	

		calendar year to inpatient services  Partial Hospitalization: \$1,500 deductible applies per calendar year to inpatient services	
	Mental health services for nonsevere mental illness	Outpatient: \$40  Inpatient: \$1,500 deductible applies per calendar year to inpatient services  Partial Hospitalization: \$1,500 deductible applies per calendar year to inpatient services	Outpatient limited to 20 visits per calendar year  Inpatient limited to 30 days maximum per calendar year  Partial Hospitalization limited to 60 days maximum per calendar year
Residential Treatment	Transitional residential recovery services.	not covered	
Chemical Dependence Services	Substance abuse treatment or rehabilitation.		
	Chemical dependency treatment	not covered	
	Acute Inpatient Care for alcohol and drug abuse (detoxification)	\$100 per day	
Home Health Services	Home health and hospice care services. **** <sup>4</sup> )		
	Home health care	\$40	100 visits per calendar year maximum; limited to three visits per day, four-hour maximum per visit
	Hospice services	covered in full	
Custodial Care and skilled nursing facilities	Skilled Nursing care and skilled nursing facilities services.		

	Skilled Nursing Facility stay	\$50 per day	Limited to 100 days per calendar year
	Custodial care services	not covered	

(\*1) This is a benefit summary. Please consult the individual plan's Evidence of Coverage for more detailed information on benefits under the plan, including any related exclusions not contained in this benefit summary.

(\*\*2) Percentage co-payments represent a percentage of actual cost. When participating providers are compensated on a fee for service basis, the actual cost is the negotiated fee rate.

(\*\*\*3) You must satisfy the prescription drug calendar year deductible (per member) before Health Net begins to cover your prescription drug expenses less any applicable copayments. Both Medications on or off the Recommended Drug List (as long as the drug is not specifically excluded) will apply towards satisfying your calendar year deductible." The prescription drug calendar year deductible does not apply to peak flow meters, inhaler spacers used for the treatment of asthma and diabetic supplies and equipment dispensed through a participating pharmacy.

(\*\*\*\*4) Hospice benefits are available through the plan. Please consult the plan's Evidence of Coverage.

**Health Net of California, Inc.**  
**HMO 15 HIPAA Plan**

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<b>Plan Name</b>	<b>Plan Contact Name and Phone Number</b>
Health Net HMO 15 HIPAA Plan Offered by Health Net of California, Inc.	Health Net Individual and Family Sales (800) 909-3447

**Coverage summary**

Eligibility requirements	<p>Applicants who meet the following requirements are eligible to enroll in Health Net's Guaranteed Issue HMOs and PPOs, without underwriting. Specific Guaranteed Issue rates apply. Only eligible individuals qualify for guaranteed issuance. To be considered an eligible individual:</p> <ul style="list-style-type: none"> <li>--The applicant must be under the age of 65</li> <li>--The applicant must not be eligible for Medicare</li> <li>--The applicant must reside continuously in our service area</li> <li>--The applicant must have a total of 18 months of coverage (including COBRA, if applicable) without a significant break (excluding any employer-imposed waiting periods) in coverage of more than 63 days.</li> <li>--The most recent coverage must have been under a group health plan (COBRA and Cal-COBRA coverage are considered group coverage).</li> <li>--The applicant must not be eligible for coverage under any group health plan, Medicare or Medicaid, and must not have other health insurance coverage.</li> <li>--The individual's most recent coverage could not have been terminated due to fraud or nonpayment of premiums.</li> <li>--If COBRA or Cal-COBRA coverage was available, it must have been elected and such coverage must have been exhausted.</li> </ul>
The full premium cost of each benefit package in the service area in which the individual and eligible dependents work or reside	See Health Net HMO 15 HIPAA Plan rates



When and under what circumstances benefits cease	<p>You may cancel your coverage at any time by giving Health Net written notice. In such event, termination will be effective on the first day of the month following our receipt of your written notice to cancel. Health Net has the right to terminate your coverage for any of the following reasons:</p> <ul style="list-style-type: none"> <li>--You do not pay your premium on time</li> <li>--You and/or your family member(s) cease being eligible</li> <li>-- You omit or misrepresent a material fact in the application</li> <li>--You and/or your family member(s) repeatedly or materially disrupt the operations of the Physician Group or Health Net to the extent that your behavior substantially impairs Health Net's ability to furnish or arrange services for you or other Health Net members, or the physician's office or Contracting Physician Group's ability to provide services to other patients.</li> <li>--You and/or your family member(s) threaten the safety of the health care provider, his or her office staff, the contracting Physician Group or Health Net personnel if such behavior does not arise from a diagnosed illness or condition.</li> </ul>
The terms under which coverage may be renewed	Subject to the termination provisions discussed, coverage will remain in effect for each month prepayment fees are received and accepted by Health Net. You will be notified 30 days in advance of any changes in fees, benefits or contract provisions.
Other coverage that may be available if benefits under the described benefit package cease	N/A
The circumstances under which choice in the selection of physicians and providers is permitted	When you enroll in this Plan, you must select a Physician Group where you want to receive all of your medical care. That Physician Group will provide or authorize all medical care. See the Health Net Individual HMO Physician Directory or call the Member Services Department at the number on your Health Net ID Card for a listing of participating providers in the Health Net Individual HMO Service Area.
<b>Annual Out-of-Pocket Maximum</b>	\$3,000 Individual/\$6,000 Family (Calendar Year Deductibles and certain copayments apply to Annual Out-of-Pocket Maximum)
Lifetime and annual maximums	No lifetime maximums
Deductibles	\$1,000 per member calendar year deductible for inpatient hospital facility services (prescription deductible applies)

<b>Benefits Summary (*1) &amp; (**2)</b>		<b>Co-payments</b>	<b>Limitation</b>
Professional Services	Physician office visits, including, but not limited to preventive care, immunizations, screenings and diagnostic visits.		
	Visit to physician	\$15	
	Specialist consultations	\$15	
	Prenatal and postnatal office visits	\$15	
	Periodic health evaluations	\$15	
	Vision screenings and exams	\$15	
	Hearing screenings and exams	\$15	
	Immunizations - Standard	\$15	
	Immunizations – To meet foreign travel or occupational requirements	20%	
	Prostate cancer screening and exam	\$15	
	Annual OB/GYN exam (breast and pelvic exams, cervical cancer screening and mammography)	\$15	
	Allergy testing	\$15	
	Allergy injection services	\$15	
	All other injections	covered in full	
	Allergy serum	covered in full	
Outpatient Services	Outpatient services, including, but not limited to surgery and treatment, and diagnostic procedures.		
	Outpatient services other than surgery	covered in full	
	Outpatient surgery	\$250	
	X-ray and laboratory procedures	covered in full	
	Rehabilitative therapy (includes physical, speech, occupational and respiratory therapy)	\$15	
	Vasectomy	\$150	
	Tubal ligation	\$150	
Hospitalization Services	Inpatient and outpatient services, including, but not limited to room board		

	and supplies.		
	Hospitalization - Semiprivate hospital room or intensive care unit with ancillary services (unlimited, except for non-severe mental health and chemical dependency treatment)	\$1,000 deductible applies per calendar year for inpatient services	
	Maternity care in hospital or skilled nursing facility	covered in full after \$1,000 inpatient hospital services deductible has been met	
	Surgeon or assistant surgeon services	covered in full	
	Physician visit to hospital (excluding care for substance abuse and mental disorders)	covered in full	
Emergency Health Coverage	Emergency room services at contracted and non-contracted facilities for medically necessary emergency services.	\$75 (waived if admitted to hospital)	
Ambulance Services	Emergency ambulance transport.	\$50	
Prescription Drug Benefits	Medically necessary drugs prescribed by a physician.		The Health Net Recommended Drug List is the approved list of medications covered for illnesses and conditions. Some drugs on the List may require prior authorization from Health Net. Drugs that are not listed on the List that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net.
	Prescription drugs filled at a participating pharmacy (up to a 30-day supply)	\$100 calendar year deductible*** <sup>3</sup> per member, then \$15 Level I (primarily	

		generic); \$25 Level II (primarily brand name, including peak flow meters and inhaler spacers); \$50 Level III Drugs on the Recommended Drug List (or drugs not on the Recommended Drug List)	
	Diabetic supplies (including but not limited to pen delivery systems and blood glucose monitoring strips, insulin needles and syringes. Lancets will be dispensed at no charge. Diabetic supplies are not subject to the prescription drug deductible.	\$25	
	Diabetic prescription medications (including but not limited to insulin and glucagon)	\$25	
Durable Medical Equipment	Home medical equipment, including, but not limited to, oxygen, parenteral and enteral nutrition, colostomy supplies, corrective prosthetics and aids, nebulizers, face masks and tubing for the treatment of asthma and diabetic supplies.		
	Durable Medical Equipment	50%	
	Prostheses	covered in full	
	Diabetic equipment (includes blood glucose monitors, insulin pumps and corrective footwear)	\$25	
Mental Health Services	Inpatient, partial hospitalization and outpatient mental health services, including, but not limited to, mental health parity services for serious mental disorders and severe emotional disturbances for children.		
	Mental health services for severe mental illness and serious emotional disturbances of child conditions	Outpatient: \$15 Inpatient: \$1,000 deductible applies per	

		calendar year to inpatient services  Partial Hospitalization: \$1,000 deductible applies per calendar year to inpatient services	
	Mental health services for nonsevere mental illness	Outpatient: \$15  Inpatient: \$1,000 deductible applies per calendar year to inpatient services  Partial Hospitalization: \$1,000 deductible applies per calendar year to inpatient services	Outpatient limited to 20 visits per calendar year  Inpatient limited to 30 days maximum per calendar year  Partial Hospitalization limited to 60 days maximum per calendar year
Residential Treatment	Transitional residential recovery services.	not covered	
Chemical Dependence Services	Substance abuse treatment or rehabilitation.		
	Chemical dependency treatment	not covered	
	Acute Inpatient Care for alcohol and drug abuse (detoxification)	\$100 per day	
Home Health Services	Home health and hospice care services. **** <sup>4</sup> )		
	Home health care	\$15	100 visits per calendar year maximum; limited to three visits per day, four-hour maximum per visit
	Hospice services	covered in full	
Custodial Care and skilled nursing facilities	Skilled Nursing care and skilled nursing facilities services.		
	Skilled Nursing Facility stay	\$50 per day	Limited to 100 days per

			calendar year
	Custodial care services	not covered	

(\*1) This is a benefit summary. Please consult the individual plan's Evidence of Coverage for more detailed information on benefits under the plan, including any related exclusions not contained in this benefit summary.

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